May 1999

This distribution contains change pages for patch WV*1*6 of the Women's Health 1.0 user manual.

The following documentation change pages should be inserted before these replacement pages:

File Name:	Patch:
WV_1_P3_UM.PDF	WV*1*3
WV_1_P5_UM.PDF	WV*1*5

Patch WV*1*6 pages:

Replace Pages:	With Pages:
iii-iv	iii-iv
2.9-2.10	2.9-2.10
4.1-4.46	4.1-4.48
AB.1-AB.2	AB.1-AB.2
IN.1-IN.2	IN.1-IN.2

Table of Contents

Autoqueue Normal MAM Letters:
This field stores a code (0 = No, 1 = Yes) that displays or hides the prompt: "QUEUE a MAM Result Normal letter to be sent to this patient?". This question displays after the user exits either Add a NEW Procedure or Edit a Procedure option and after the results of a mammogram procedure have been entered into the patient's record. The results/diagnosis must be considered normal.

MAM Result Normal Letter:
This field stores the name of the MAM letter that is printed when the user answers, YES, to the prompt: "QUEUE a MAM Result Normal letter to be sent to this patient?" after the procedures results have been entered into a patient's record.

Default #days to print Letters:
Allows the ADPAC to set the default number of days each type of procedure is allowed to remain open before being listed as delinquent. For example, the default for PAPs may be 30 days, but for colposcopies only 14 days, and mammograms only 5 days.

Import Mammograms from Radiology:
This field is used to automatically import and store mammography reports, from the Radiology/Nuclear Medicine package, in the Women's Health database.
NOTE: The Radiology/Nuclear Medicine patch RA*5.0*2 must be installed to use this functionality.

Status Given to Imported Mammograms:
This field automatically stores a default status (O = Open; C = Closed) in the procedure edit screens when mammography reports are imported from the Radiology/Nuclear Medicine application.

Import Test from Laboratory:
This field indicates whether or not to automatically import lab test data from the Laboratory package, into the Women's Health database.
NOTE: The Lab patch LR*5.2*231 must be installed to use this functionality.

After answering the page 2 site parameters, the cursor will drop to the Command Line. Selecting a 'N' (for Next page) at the command prompt will display page 3. pages 3, 4 and 5 all concern setting the parameters for each of the 27 procedure types.

Procedure Type:
This is not an editable field. It simply lists all of the procedure types that are available for tracking in the Women's Health package.

Active:
If users should NOT be allowed to select a specific procedure type when entering new procedures at this site, then enter 'No' to make it 'Inactive' or unselectable. Enter 'Yes' to make the procedure type 'Active'.

Days Delinquent:
Enter the default number of days that a specific procedure will be allowed to remain ‘Open’ before being marked as ‘Delinquent’.

Pages 4 and 5 of the ‘Edit Site Parameters’ screen are similar to page 3 and permit the configuration of the remaining procedure types.

Chapter 4 Patient Management Menu

WV MENU-PATIENT MANAGEMENT

Patient Management

The Patient Management Menu is divided into three groups of options: the patient related options, the procedure related options, and the notification related options.

The patient related options deal mainly with managing patients. The procedure related options deal more directly with the adding, editing and printing of procedures. The notification related options deal mostly with the adding, editing and printing of notifications.

Menu Display:

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Select OPTION NAME: WV MENU-PATIENT MANAGEMENT          Patient Management

   WOMEN'S HEALTH:       *  PATIENT MANAGEMENT MENU  *       HINES DEVELOPMENT
                         ============================


   PC     Edit/Print Patient Case Data
   PP     Patient Profile
   FS     Print Patient Demographic Info (Face Sheet)
   BD     Browse Patients With Needs Past Due
   LAB    Save Lab Test as Procedure
   AP     Add a NEW Procedure
   EP     Edit a Procedure
   HS     Health Summary
   BP     Browse Procedures
   PR     Print a Procedure
   HIS    Add an HISTORICAL Procedure
   RA     Add a Refusal of Treatment
   RE     Edit a Refusal of Treatment
   AN     Add a New Notification
   EN     Edit a Notification
   BN     Browse Notifications
   PL     Print Individual Letters
   PQ     Print Queued Letters
```

WV EDIT PATIENT CASE DATA

Edit/Print Patient Case Data

This option allows you to add a new patient and her case data to the Women's Health register. It also allows you to edit the case data of patients already in the register. When you add or edit a patient's case data, you will be presented with the 'Edit Patient Case Data' screen.

The fields in the top third of the screen (patient name, address, SSN, and phone number) are editable only through the PIMS Registration module. Patient data is stored in the WV Patient (#790) file.

Field Descriptions:

These fields appear above the dashed line on every screen:

Patient Name:
This field contains the name of the patient associated with the procedure. Pointer to the WV Patient (#790) file.

Street:
This field contains the patients street address.

City/State/Zip:
This field contains the patient's city, state, and zip code.

SSN:
This field contains the social security number of the patient.

Patient Phone:
This field contains the patient's phone number.

Primary Provider:
This field contains the name of the patient's primary caregiver.

Veteran:
This field contains a 'Yes' if the patient is a veteran, 'No' if the patient is not a veteran, or is blank if the veteran status of this patient is not known.

These fields appear below the dashed line:

Case Manager:
This field contains the name of a person who is currently managing the women's health care needs of this patient. NOTE: All case managers must be entered by the ADPAC under the File Maintenance Menu.

Date Inactive:
This field contains the date on which this patient's record became inactive. ANY date (past, present or future) will cause this patient's data to be excluded from all reports that assess treatment needs (i.e., Snapshot of the Program Today report and Browse Patients with Needs Past Due).

Breast Treatment Need:
This field contains the name of the current or next breast study procedure needed for this patient.

Breast Tx Due Date:
This field contains the date by which the breast Tx procedure should be completed.

Breast Tx Facility:
The name of the facility responsible for providing the breast study tests/exams for this patient. Facility choices are limited to entries in the Institution (#4) file.

Cervical Treatment Need:
This field contains the name of the current or next gynecologic procedure or treatment need scheduled for this patient.

Cervical Tx Due Date:
This field contains the date when this gynecologic procedure or treatment should be completed.

Cervical Tx Facility:
The name of the facility responsible for providing the gynecological tests/exams for this patient. Facility choices are limited to entries in the Institution (#4) file.

PAP Regimen:
This field stores the current PAP regimen for the patient. The regimen appears in an abbreviated form so that it can be listed on several screens where there is limited space. The following abbreviations apply:

symbol	meaning
P	PAP
C	colposcopy
wk	week
m	month
y	year
q	every
pp	postpartum
x2	times 2
x3	times 3
ga	gestation

The abbreviations read much like a prescription. For example, 'Pq6mx2, Pqy' stands for 'PAP every 6 months times 2, then PAP every year (annually)'. Another example, 'P6wkpp, C8-12wkpp' stands for 'PAP at 6 weeks postpartum, then colposcopy 8 to 12 weeks postpartum'.

PAP Regimen Start Date:
This field stores a date on which the patient began or will begin her current PAP regimen.

Sexual Trauma:
This field indicates if the patient has experienced any sexual trauma (rape, sexual assault, etc.) either in the military and/or as a civilian. Set of codes: (M = Military, C = Civilian, B = Both).

Family Hx of Breast CA:
This field identifies if the patient's relatives have had breast cancer. The information may be selected from a set of codes to indicate no family history, a 2nd degree relative (cousin, aunt, grandmother), a 1st degree relative (mother OR sister) or multiple 1st degree relatives (mother AND sister).

Notes (WP):
This is a word processing field that stores additional information about the patient and her health care needs.

Currently Pregnant:
This field contains information on the pregnancy status of the patient. The status is a set of codes: 1 = Yes if this patient is currently pregnant, 0 = No, if not. When the pregnancy status is unknown, the field is blank.

EDC:
This field stores the patient's delivery date or estimated date of confinement (EDC).

DES Daughter:
This field indicates if this patient's mother took diethylstilbestrol (DES) when she was pregnant with this patient. If unknown, leave this field blank.

Date of 1st Encounter:
This field contains the date of the patient's first clinic visit. Although a date is automatically stuffed when the Automatically Load Patients [WV AUTOLOAD PATIENTS] option is run, the information can be edited through the Edit/Print Patient Case Data option.

Referral Source:
This field stores information on who referred the patient or how the patient found out about the women's health care services at the facility. This field points to entries in the WV Referral Source (#790.07) file. Additional choices may be added by the facility via the option Add/Edit to Referral Source File.

After exiting the 'Edit Patient Case Data' screen you will be given the opportunity to print the patient's case data to a device.

WV PATIENT PROFILE

Patient Profile

This option allows you to list all of the procedures and notifications associated with an individual patient. If you choose the brief format, only the patient's procedures will be listed. If you choose the detailed format, both procedures and notifications, as well as PAP regimen changes and pregnancies will be listed.

The patient's case data is shown above the double-dashed line, while the procedures, their dates, results, and status are shown below. If the device selected for the patient profile is 'Home' (to the screen), a column of numbers will appear to the left of the procedures (and of the notifications in the detailed report). Patient data is stored in the WV Patient (#790) file.

Report Description:

These fields appear above the dashed line, and appear on every page of the report:

Patient Name:
This field contains the name of the patient associated with the procedure. Pointer to the WV Patient (#790) file.

SSN:
This field contains the social security number of the patient.

Case Manager:
This field contains the name of a person who is currently managing the women's health care needs of this patient.

Facility:
This field contains the name of the facility responsible for the women's health care needs of this patient. If the health care facility you wish to select is not available in this file, contact your site manager or ADPAC. Pointer to the Institution (or Facility) (#4) file.

Cervical Treatment Need:
This field contains the name of the current or next gynecologic procedure or treatment need scheduled for this patient.

Cervical Treatment Facility:
This field contains the name of the facility responsible for providing the gynecological tests/exams for this patient. Facility choices are limited to entries in the Institution (#4) file.

PAP Regimen:
This field contains the PAP regimen that was given to this patient at the date and time of this entry.

Breast Treatment Need:
This field contains the name of the current or next breast study procedure needed for this patient.

Breast Treatment Facility:
This field contains the name of the facility responsible for providing the breast study tests/exams for this patient. Facility choices are limited to entries in the Institution (#4) file.

Primary Provider:
This field contains the name of the primary provider who is responsible for the women's health care needs of this patient.

Sexual Trauma:
This field indicates if the patient has experienced any sexual trauma (rape, sexual assault, etc.) either in the military and/or as a civilian. Set of codes: (M = Military, C = Civilian, B = Both).

Family Hx of Breast CA:
This field identifies if the patient's relatives have had breast cancer. The information may be selected from a set of codes to indicate no family history, a 2nd degree relative (cousin, aunt, grandmother), a 1st degree relative (mother OR sister) or multiple 1st degree relatives (mother AND sister).

Veteran:
This field contains a 'Yes' if the patient is a veteran, 'No' if the patient is not a veteran, or is blank if the veteran status of this patient is not known.

These fields appear below the dashed line:

Date:
This field contains the date the procedure was performed.

Procedure:
This field displays the abbreviation of the procedure (type) performed on the patient. Pointer to the WV Procedure (#790.1) file.

Results/Diagnosis:
This field displays the main result or diagnosis of the patient's procedure. Pointer to the WV Results/Diagnosis (#790.31) file. The diagnosis or results for PAP smears are based on the Bethesda Classification system; those for mammograms use the American College of Radiology classification. Entries should not be locally edited. A list of the possible results/diagnosis for each procedure type is found in Appendix A.

Status:
This field contains the record's status (set of codes: O = Open, C = Closed, D = Delinquent) for the procedure. The value of this field is used in the Program Snapshot reports and the Browse Patients with Needs Past Due report.

The following fields only appear on the detailed report:

PAP Regimen Change:
This is the beginning date of change and the name of the new regimen.

Pregnancy Status:
This field contains information on the pregnancy status of the patient. The status is a set of codes: 1 = Yes if this patient is currently pregnant, 0 = No, if not. When the pregnancy status is unknown, the field is blank.

Notifications:
This includes the procedure accession number and name associated with the notification, notification outcome, status, purpose and type.

Procedures:
This field includes the Women's Health procedure accession number.

WV PATIENT DEMOGRAPHIC INFO

Print Patient Demographic Info (Face Sheet)

This option allows you to display or print patient demographic information. It provides information such as the patient's address, phone numbers, spouse, emergency contacts and billing information. Patient demographic data is stored in the Patient (#2) file.

Field Descriptions:

Name:
This field contains the name of the patient. It is a pointer to the Patient (#2) file.

SSN:
This computed field displays the patient's social security number from the Patient (#2) file.

Address:
This field contains the address of the patient.

County:
This field contains the name of the county where the patient lives.

Phone:
This field contains the patient's phone number.

Office:
This field contains the patient's office phone number.

Temporary:
This field contains the patient's temporary address, if there is one.

From/To:
This field contains the from/to dates in which the patient lived at the temporary address.

Phone:
This field contains the phone number for the temporary address.

Primary Eligibility:
This field contains the primary benefits eligibility code for this patient.

Other Eligibilities:
This field contains any other benefits eligibility codes for this patient.

Status:
This field contains the eligibility status for this patient.

Discharge Type:
This field contains the type of discharge which the patient received for her most recent episode of military service.

Admitted:
This is the date the patient was admitted to the hospital.

Discharged:
This is the date the patient was discharged from the hospital.

Ward:
This field contains the current ward location on which this patient is residing if an inpatient.

Room-Bed:
This field contains the current room and bed on which this patient is residing if an inpatient.

Provider:
This field stores the name of the provider currently assigned to this patient.

Specialty:
This field contains the treating specialty to which this inpatient is currently assigned.

Attending:
This field contains the name of the attending physician currently responsible for the care of this patient.

Admission LOS:
This field contains the number of days the patient has been in the hospital during the current stay.

Absence Days:
This field contains the number of days the patient has been absent from the hospital.

Pass Days:
This field contains the number of days the patient has been on pass.

ASIH Days:
The field contains the number of days the patient is Absent Sick In Hospital (ASIH).

Currently enrolled in:
This field contains any insurance programs the patient is currently enrolled in.

Future Appointments:
This field contains a list of any future appointments the patient may have.

Remarks:
This field contains any short comments the user may wish to enter about this patient.

WV BROWSE NEEDS PAST DUE

Browse Patients With Needs Past Due

This option allows you to search for and browse through patients whose treatment needs are past due. The five questions that are asked prior to the display allow you to specify the needs, dates, case managers, order of display, and device for the display.

NOTE: It may be useful to select a date at some time in the future, for example, two weeks ahead, in order to anticipate which patients will become delinquent and to act on those cases ahead of time.

If the device selected is 'Home' (to the screen), a column of numbers will appear to the left of the chart numbers.

A patient will not be processed if there is any value (past, present, or future) in the Date Inactive field on the Edit/Print Patient Case Data option screen. Patient needs past due data is stored in the WV Patient (#790) file.

Report Description:

SSN:
This field contains the social security number of the patient.

Patient:
This field contains the name of the patient associated with the procedure. Pointer to the WV Patient (#790) file.

Case Manager:
This field contains the name of a person who is currently managing the women's health care needs of this patient.

Treatment Need and Due by Date:
This field contains the name of the current or next procedure or treatment need scheduled for this patient, including the due by date.

Primary Care Provider:
This field contains the name of the primary provider who is responsible for the women's health care needs of this patient.

WV SAVE LAB TEST

Save Lab Test as Procedure

This option is used to save lab tests as procedure entries in the Women's Health package. Lab tests for cytology and surgical pathology are passed to the Women's Health package from the Lab package and stored in the WV Lab Tests (#790.08) file. A mail message is sent to the patient's case manager stating a lab test has been released to the Women's Health package. This option allows the user to first view the lab tests in an uneditable screen, then dispose of the lab tests either by 1) adding the lab test data into a Women's Health package procedure, 2) deleting the lab test from the WV Lab Tests file (i.e., don't convert it into a Women's Health procedure), or 3) ignore the lab test for the time being. The lab test can be looked up by requesting provider, lab accession, patient name or SSN, or date of test.

If the user chooses to add the lab test to the Women's Health package, the user is first asked to select a WH procedure type, to associate with the lab test (e.g., PAP Smear). The lab test is saved as a Women's Health procedure in the WV Procedure (#790.1) file. The user is placed in the procedure data entry screen and may edit/close out the procedure entry. The lab report can be viewed again by going into the Reports (WP) field.

The software may provide a default response at the "Select Lab Test Accession #:" prompt. The software checks each entry, if the user is the requesting provider for a test, or the Women's Health case manager for a patient, that entry will be displayed as a default response. A default response is provided until the user has looped through all associated tests or up-arrows out of the option. The user may enter a question mark to see a list of all entries or select any entry to process.

Note: This option can only work if the Lab package patch LR*5.2*231 is installed and the "Import Test from Laboratory" field is set to 'Yes' for the facility in the Edit Site Parameters [WV EDIT SITE PARAMETERS] option.

It is possible that the wrong patient was originally associated with a lab test. When this happens, the Lab package has an option to associate the correct patient with the lab test. The Lab package contains a check that will call the Women's Health package if a lab test is moved from one patient to another. If the lab test was converted into a Women's Health procedure entry the Women's Health package does the following:

1. Disassociates the Women's Health entry from the Lab package entry (i.e., will not delete the Women's Health entry, but will not show the lab results).
2. Changes the Result/Dx of the Women's Health entry to 'Error/disregard'.
3. Sends a mail message to the case manager stating lab results no longer belong to that patient and identify the Women's Health entry. The case manager can then make any additional changes or add notes to the record.
4. If the new patient associated with the lab test is female, then the lab test will be passed to the Women's Health package and stored as a new entry in the WV Lab Test (#790.08) file.

If the results of a lab test are ever edited by the Lab user, and the lab test was saved as a WH procedure entry, the case manager will receive a mail message indicating the lab report has changed. Also, the status of the WH procedure entry will be set to 'Open', and the Complete by (Date) is updated.

WV ADD A NEW PROCEDURE

Add a NEW Procedure

This option allows you to add procedures for patients. The first prompt asks you to select a patient (either by name, or SSN). The second prompt asks you to select a procedure. The possible choices of procedures are listed in the table below:

Breast Ultrasound - BU	Laser Cone - LC
Clinical Breast Exam - CB	LEEP - LP
Colposcopy Impression (No BX) -CI	Lumpectomy - LM
Colposcopy w/Biopsy - CO	Mammogram Dx Unilat - MU
Cone Biopsy - CN	Mammogram Dx Bilat - MB
Cryotherapy - CY	Mammogram Screening - MS
Ectocervical Biopsy - EB	Mastectomy - MT
Endocervical Curettage - EC	Needle Biopsy - NB
Endometrial Biopsy - EM	Open Biopsy - OB
Fine Needle Aspiration - FN	PAP Smear - PS
General Surgery Consult - GS	Pregnancy Test - PT
GYN ONC Consult - GY	STD Evaluation - ST
Hysterectomy - HY	Stereotactic Biopsy - SB
Laser Ablation – LA	

The procedure is selected by typing either its name or its abbreviated code, for example, ‘PS’ will select ‘PAP Smear’. (These codes are also used in the accession numbers, for example, ‘PS1998-43’ will be an accession# for a PAP smear.)

If the procedure is a unilateral mammogram, an additional prompt will ask you to enter ‘Left or Right’. If the procedure is a colposcopy w/biopsy, an additional prompt will ask you to select the accession# of the PAP that initiated this colposcopy.

A final prompt asks you for the date of the procedure. At this point the computer checks to see if this procedure has already been entered for this patient on this date. If so, then this would be a duplicate procedure.

Once you have added a valid new procedure, the program will automatically assign the procedure a unique accession# and then proceed to the ‘Edit a Procedure’ screen. the accession# for a procedure uniquely identifies that procedure for all editing and reporting purposes. Procedure data is stored in the WV Procedure (#790.1) file.

Field Descriptions:

These fields appear above the dashed line on every screen. These fields are not editable through this option. They may be edited through Edit/Print Patient Case Data option (except patient name and SSN).

Patient Name:
This field contains the name of the patient associated with the procedure. Pointer to the WV Patient (#790) file.

SSN:
This field contains the social security number of the patient.

Case Manager:
This field contains the name of a WH case manager assigned to manage this women's health needs.

Procedure:
This field stores the name of the procedure performed on the patient. Pointer to the WV Procedure (#790.1) file.

PAP Regimen:
This field contains the PAP regimen that was given to this patient at the date and time of this entry.

Accession#:
This is the record number assigned by the Women's Health package. It is composed of the procedure's abbreviated code, a four digit year and a sequential number.

Cervical Treatment Need:
This field contains the name of the current or next gynecologic procedure or treatment need scheduled for this patient.

Cervical Treatment Facility:
This field contains the name of the facility responsible for providing the gynecological tests/exams for this patient. Facility choices are limited to entries in the Institution (#4) file.

Breast Treatment Need:
This field contains the name of the current or next breast study procedure needed for this patient.

Breast Treatment Facility:
This field contains the name of the facility responsible for providing the breast study tests/exams for this patient. Facility choices are limited to entries in the Institution (#4) file.

Sexual Trauma:
This field indicates if the patient has experienced any sexual trauma (rape, sexual assault, etc.) either in the military and/or as a civilian. Set of codes: (M = Military, C = Civilian, B = Both).

Veteran:
This field contains a 'Yes' if the patient is a veteran, 'No' if the patient is not a veteran, or is blank if the veteran status of this patient is not known.

These fields appear below the dashed line:

Date of Procedure (Required):
This field identifies the date on which the procedure was performed. Dates in the future may not be entered.

Clinician/Provider:
This field stores the name of the clinician who ordered and/or performed this procedure.

Ward/Clinic/Location:
This field contains the name of the ward, clinic, or location where the procedure was performed. NOTE: If the entry in the Hospital Location (#44) file has the Institution (#3) field filled in, the institution will be provided as the default for the field Health Care Facility.

Reports (WP):
If the report is from a Radiology/NM procedure, this field contains data from the Radiology/NM Report (#74) file. If a radiology report is unverified and then verified again, the words " AMENDED REPORT" will appear with the data displayed in this field. If the report is from a lab test, this field contains data from the Lab Data (#63) file. Users can get to this field by using the TAB key from the Ward/Clinic/Location field.

Health Care Facility (Required):
This field identifies the name of the health care facility where this procedure was performed.

Notes (WP):
A word-processing field for storing extensive notes/comments about this case. If there is text data present, a '+' will appear to the right of the field label, like so: (WP): +. Users can get to this field by using the TAB key from the Health Care Facility field.

Comments:
An optional one-line clinical history note (limited to 78 characters).

Complete by (Date):
This field contains the date used to determine that this procedure record is delinquent when a close status has not been entered in the record.

Results/Diagnosis:
This field stores the main result or diagnosis of the patient's procedure. Pointer to the WV Results/Diagnosis (#790.31) file. The diagnosis or results for PAP smears are based on the Bethesda Classification system; those for mammograms use the American College of Radiology classification. Entries should not be locally edited. A list of the possible results/diagnosis for each procedure type is found in Appendix A.
NOTE: **Procedures cannot be deleted.** If a procedure has been entered in error or is invalid for some other reason, enter a results/diagnosis of 'Error/disregard'. Procedures with a results/diagnosis of 'Error/disregard' will not appear on Patient Profiles, nor will they be included in the various epidemiology reports. These procedures can be viewed only under the Patient Profile Including Errors option of the Manager's Patient Management menu.

HPV:
This field is used to document the presence or absence of the Human Papilloma Virus (HPV) in the cytology reports.

Sec Results/Diagnosis:
This field stores a secondary outcome/diagnosis associated with the procedure. Pointer to the WV Results/Diagnosis (#790.31) file.

Status:
This field contains the record's status (set of codes: O = Open, C = Closed, D = Delinquent) for the procedure. The value of this field is used in the Program Snapshot reports and the Browse Patients with Needs Past Due report.

(page 1 of 2):
Some procedures, such as colposcopy, cone biopsy, laser cone, and LEEP, will have a page 2 to the 'Edit a Procedure' screen. This is indicated by the words '(page 1 of 2)' on page 1. Page 2 is concerned with the clinical findings and tissue pathology results of colposcopy and similar procedures.

If there is no page 2 of data fields to be edited, then when you have completed the edits for this page you would save and exit this procedure via the command line at the bottom of the screen.

Page 2 – Colposcopy:

The clinical findings (for page 2) are usually found on a form used by the physician performing the colposcopy or biopsy. The tissue pathology report section would be used most commonly for colposcopies in which an ECC and a biopsy were performed at the same time as the colposcopy. Therefore, you will not need to add separate procedures for a biopsy and ECC if they are done with a colposcopy.

Screening PAP:
This field stores the PAP procedure associated with the follow-up procedure (e.g., colposcopy). Pointer to the WV Procedure (#790.1) file.

T-Zone Seen Entirely:
This field documents (set of codes: 1 = Yes, 0 = No) that the T-Zone in the colposcopy/biopsy procedure was adequately visualized.

Multifocal:
This field documents (set of codes: 1 = Yes, 0 = No) that the lesion seen during the procedure was multifocal (as opposed to unifocal).

Lesion Outside Canal:
This field documents (set of codes: 1 = Yes, 0 = No) that the lesion seen during the procedure was outside the canal.

Number of Quadrants:
This field contains a number (0-4) that identifies the number of quadrants occupied by the lesion.

Satisfactory Exam:
This field documents that the procedure or gynecologic exam was satisfactorily performed without any impediments. Set of codes (1 = Yes, 0 = No).

Quadrant Locations:
The location of the affected quadrants. Any of the following abbreviations may be selected: UL,LL,UR,LR. If more than one quadrant is included, separate them with a comma.

Impression:
This field contains the impression of the clinician performing the exam. Pointer to the WV Results/Diagnosis (#790.31) file.

ECC Dysplasia:
This field indicates if ectocervical dysplasia was present, if an insufficient tissue sample was provided, or the sample was not examined for dysplasia.

Margins Clear:
This field indicates tissue sample showed no pathology at the margins of the tissue sample.

Ectocervical Biopsy:
This field contains the diagnosis or impression resulting from the cytology examination. Pointer to the WV Results/Diagnosis (#790.31) file.

Stage:
This field documents the clinical stage for invasive carcinoma of the cervix. If clinical stage is unknown, enter the summary ('S-') stage.

STD Evaluation:
This field documents the findings after testing for sexually transmitted diseases. Pointer to the WV Results/Diagnosis (#790.31) file.

WV EDIT PROCEDURE

Edit a Procedure

This option allows you to edit previously documented procedures for patients. The first prompt asks you to select an accession# or patient name. A patient's SSN may also be entered. An accession# would be of the form 'PS1998-24'. If you know the accession# of the procedure you wish to edit, it will be more efficient to select the procedure by its accession# rather than by its patient (some patients will have several procedures on file). Procedure data is stored in the WV Procedure (#790.1) file.

Field Descriptions:

Page 1 - All Procedures:

These fields appear above the dashed line on every screen. These fields are not editable through this option. They may be edited through Edit/Print Patient Case Data option (except patient name and SSN).

Patient Name:
This field contains the name of the patient associated with the procedure. Pointer to the WV Patient (#790) file.

SSN:
This field contains the social security number of the patient.

Case Manager:
This field contains the name of a WH case manager assigned to manage this women's health needs.

Procedure:
This field stores the name of the procedure performed on the patient. Pointer to the WV Procedure (#790.1) file.

PAP Regimen:
This field contains the PAP regimen that was given to this patient at the date and time of this entry.

Accession#:
This is the record number assigned by the Women's Health package. It is composed of the procedure's abbreviated code, a four digit year and a sequential number.

Cervical Treatment Need:
This field contains the name of the current or next gynecologic procedure or treatment need scheduled for this patient.

Cervical Treatment Facility:
This field contains the name of the facility responsible for providing the gynecological tests/exams for this patient. Facility choices are limited to entries in the Institution (#4) file.

Breast Treatment Need:
This field contains the name of the current or next breast study procedure needed for this patient.

Breast Treatment Facility:
This field contains the name of the facility responsible for providing the breast study tests/exams for this patient. Facility choices are limited to entries in the Institution (#4) file.

Sexual Trauma:
This field indicates if the patient has experienced any sexual trauma (rape, sexual assault, etc.) either in the military and/or as a civilian. Set of codes: (M = Military, C = Civilian, B = Both).

Veteran:
This field contains a 'Yes' if the patient is a veteran, 'No' if the patient is not a veteran, or is blank if the veteran status of this patient is not known.

These fields appear below the dashed line:

Date of Procedure (Required):
This field identifies the date on which the procedure was performed. Dates in the future may not be entered.

Clinician/Provider:
This field stores the name of the clinician who ordered and/or performed this procedure.

Ward/Clinic/Location:
This field contains the name of the ward, clinic, or location where the procedure was performed. NOTE: If the entry in the Hospital Location (#44) file has the Institution (#3) field filled in, the institution will be provided as the default for the field Health Care Facility.

Reports (WP):
If the report is from a Radiology/NM procedure, this field contains data from the Radiology/NM Report (#74) file. If a radiology report is unverified and then verified again, the words "AMENDED REPORT" will appear with the data displayed in this field. If the report is from a lab test, this field contains data from the Lab Data (#63) file. Users can get to this field by using the TAB key from the Ward/Clinic/Location field.

Health Care Facility (Required):
This field identifies the name of the health care facility where this procedure was performed.

Notes (WP):
A word-processing field for storing extensive notes/comments about this case. If there is text data present, a '+' will appear to the right of the field label, like so: (WP): +. Users can get to this field by using the TAB key from the Health Care Facility field.

Comments:
An optional one-line clinical history note (limited to 78 characters).

Complete by (Date):
This field contains the date used to determine that this procedure record is delinquent when a close status has not been entered in the record.

Results/Diagnosis:
This field stores the main result or diagnosis of the patient's procedure. Pointer to the WV Results/Diagnosis (#790.31) file. The diagnosis or results for PAP smears are based on the Bethesda Classification system; those for mammograms use the American College of Radiology classification. Entries should not be locally edited. A list of the possible results/diagnosis for each procedure type is found in Appendix A.
NOTE: **Procedures cannot be deleted.** If a procedure has been entered in error or is invalid for some other reason, enter a results/diagnosis of 'Error/disregard'. Procedures with a results/diagnosis of 'Error/disregard' will not appear on Patient Profiles, nor will they be included in the various epidemiology reports. These procedures can be viewed only under the Patient Profile Including Errors option of the Manager's Patient Management menu.

HPV:
This field is used to document the presence or absence of the Human Papilloma Virus (HPV) in the cytology reports.

Sec Results/Diagnosis:
This field stores a secondary outcome/diagnosis associated with the procedure. Pointer to the WV Results/Diagnosis (#790.31) file.

Status:
This field contains the record's status (set of codes: O = Open, C = Closed, D = Delinquent) for the procedure. The value of this field is used in the Program Snapshot reports and the Browse Patients with Needs Past Due report.

(page 1 of 2):
Some procedures, such as colposcopy, cone biopsy, laser cone, and LEEP, will have a page 2 to the 'Edit a Procedure' screen. This is indicated by the words '(page 1 of 2)' on page 1. Page 2 is concerned with the clinical findings and tissue pathology results of colposcopy and similar procedures.

If there is no page 2 of data fields to be edited, then when you have completed the edits for this page you would save and exit this procedure via the command line at the bottom of the screen.

Page 2 – Colposcopy:

The clinical findings (for page 2) are usually found on a form used by the physician performing the colposcopy or biopsy. The tissue pathology report section would be used most commonly for colposcopies in which an ECC and a biopsy were performed at the same time as the colposcopy. Therefore, you will not need to add separate procedures for a biopsy and ECC if they are done with a colposcopy.

Screening PAP:
This field stores the PAP procedure associated with the follow-up procedure (e.g., colposcopy). Pointer to the WV Procedure (#790.1) file.

T-Zone Seen Entirely:
This field documents (set of codes: 1 = Yes, 0 = No) that the T-Zone in the colposcopy/biopsy procedure was adequately visualized.

Multifocal:
This field documents (set of codes: 1 = Yes, 0 = No) that the lesion seen during the procedure was multifocal (as opposed to unifocal).

Lesion Outside Canal:
This field documents (set of codes: 1 = Yes, 0 = No) that the lesion seen during the procedure was outside the canal.

Number of Quadrants:
This field contains a number (0-4) that identifies the number of quadrants occupied by the lesion.

Satisfactory Exam:
This field documents that the procedure or gynecologic exam was satisfactorily performed without any impediments. Set of codes (1 = Yes, 0 = No).

Quadrant Locations:
The location of the affected quadrants. Any of the following abbreviations may be selected: UL,LL,UR,LR. If more than one quadrant is included, separate them with a comma.

Impression:
This field contains the impression of the clinician performing the exam. Pointer to the WV Results/Diagnosis (#790.31) file.

ECC Dysplasia:
This field indicates if ectocervical dysplasia was present, if an insufficient tissue sample was provided, or the sample was not examined for dysplasia.

Margins Clear:
This field indicates tissue sample showed no pathology at the margins of the tissue sample.

Ectocervical Biopsy:
This field contains the diagnosis or impression resulting from the cytology examination. Pointer to the WV Results/Diagnosis (#790.31) file.

Stage:
This field documents the clinical stage for invasive carcinoma of the cervix. If clinical stage is unknown, enter the summary ('S-') stage.

STD Evaluation:
This field documents the findings after testing for sexually transmitted diseases. Pointer to the WV Results/Diagnosis (#790.31) file.

WV HS-USER DEFINED

Health Summary

This option allows the user to create a Health Summary report for a specific patient. The user may select multiple Health Summary components to create the health summary report.

The user selects a patient, then selects one or more Health Summary components such as Cytology or Surgical Pathology. The Health Summary components offer default values for the number of occurrences to return and time span to cover. For example, after selecting the Cytology component for display, the default values for time limit may be 1 year, and number of occurrences to display may be 10. This means the Health Summary package will search the lab database for Cytology tests from 1 year ago up to today. The 10 most recent tests will be displayed. The user may edit the default limits for each of the selected components at the "Select COMPONENT(S) to EDIT or other COMPONENT(S) to ADD:" prompt. After selecting one or more of the components, the user can then edit the default for number of occurrences to return at the "OCCURRENCE LIMIT:" prompt, and the default time span to cover at the "TIME LIMIT:" prompt. Also, a special "HEADER NAME:" may be assigned to the report output. The user is then asked to select a device.

WV BROWSE PROCEDURES

Browse Procedures

This option allows you to search for and list procedures. The eight questions that are asked prior to the display allow you to specify patients, procedures, date range, status, normal/abnormal, case manager (site parameter), order of display, and device for the printout.

If the device selected for the 'Browse Procedures' display is 'Home' (to the screen), a column of numbers will appear to the left of the procedures. Procedure data is stored in the WV Procedure (#790.1) file.

Report Description:

SSN:
This field contains the social security number of the patient.

Patient:
This field contains the name of the patient associated with the procedure. Pointer to the WV Patient (#790) file.

Date:
This field contains the date the procedure was performed.

Accession#:
This is the record number assigned by the Women's Health package. It is composed of the procedure's abbreviated code, a four digit year and a sequential number.

Status:
This field contains the record's status (set of codes: O = Open, C = Closed, D = Delinquent) for the procedure. The value of this field is used in the Program Snapshot reports and the Browse Patients with Needs Past Due report.

Results/Diagnosis:
This field displays the main result or diagnosis of the patient's procedure. Pointer to the WV Results/Diagnosis (#790.31) file. The diagnosis or results for PAP smears are based on the Bethesda Classification system; those for mammograms use the American College of Radiology classification. Entries should not be locally edited. A list of the possible results/diagnosis for each procedure type is found in Appendix A.

WV PRINT A PROCEDURE

Print a Procedure

This option allows you to print information pertaining to a patient's procedure. You are prompted for an accession# or patient name, and for a device. The display/printout looks very similar to the 'Edit a Procedure' screen. Procedure data is stored in the WV Procedure (#790.1) file.

Report Description:

These fields appear on the top of every page of the report:

Patient Name:
This field contains the name of the patient associated with the procedure. Pointer to the WV Patient (#790) file.

SSN:
This field contains the social security number of the patient.

Case Manager:
This field contains the name of a WH case manager assigned to manage this women's health needs.

Procedure:
This field displays the name of the procedure performed on the patient. Pointer to the WV Procedure (#790.1) file.

PAP Regimen:
This field contains the PAP regimen that was given to this patient at the date and time of this entry.

Accession#:
This is the record number assigned by the Women's Health package. It is composed of the procedure's abbreviated code, a four digit year and a sequential number.

Cervical Treatment Need:
This field contains the name of the current or next gynecologic procedure or treatment need scheduled for this patient.

Cervical Treatment Facility:
This field contains the name of the facility responsible for providing the gynecological tests/exams for this patient. Facility choices are limited to entries in the Institution (#4) file.

Breast Treatment Need:
This field contains the name of the current or next breast study procedure needed for this patient.

Breast Treatment Facility:
This field contains the name of the facility responsible for providing the breast study tests/exams for this patient. Facility choices are limited to entries in the Institution (#4) file.

Sexual Trauma:
This field indicates if the patient has experienced any sexual trauma (rape, sexual assault, etc.) either in the military and/or as a civilian. Set of codes: (M = Military, C = Civilian, B = Both).

Veteran:
This field contains a 'Yes' if the patient is a veteran, 'No' if the patient is not a veteran, or is blank if the veteran status of this patient is not known.

Page 1:

Date of Procedure:
This field identifies the date on which the procedure was performed. Dates in the future may not be entered.

Date First Entered:
This field displays the date on which this procedure record was first entered.

First Entered By:
This field identifies the name of the person who first entered data on this procedure.

Clinician/Provider:
This field displays the name of the clinician who ordered and/or performed this procedure.

Ward/Clinic/Location:
This field contains the name of the ward, clinic, or location where the procedure was performed. NOTE: If the entry in the Hospital Location (#44) file has the Institution (#3) field filled in, the institution will be provided as the default for the field Health Care Facility.

Health Care Facility:
This field identifies the name of the health care facility where this procedure was performed.

Comments:
An optional one-line clinical history note (limited to 78 characters).

Complete by (Date):
This field contains the date used to determine that this procedure record is delinquent when a close status has not been entered in the record.

Results/Diagnosis:
This field displays the main result or diagnosis of the patient's procedure. Pointer to the WV Results/Diagnosis (#790.31) file. The diagnosis or results for PAP smears are based on the Bethesda Classification system; those for mammograms use the American College of Radiology classification. Entries should not be locally edited. A list of the possible results/diagnosis for each procedure type is found in Appendix A.

Sec Results/Diagnosis:
This field displays a secondary outcome/diagnosis associated with the procedure. Pointer to the WV Results/Diagnosis (#790.31) file.

HPV:
This field displays the presence or absence of the Human Papilloma Virus (HPV) in the cytology reports.

Status:
This field contains the record's status (set of codes: O = Open, C = Closed, D = Delinquent) for the procedure. The value of this field is used in the Program Snapshot reports and the Browse Patients with Needs Past Due report.

Page 2 (for colposcopy only):

Screening PAP:
This field displays the PAP procedure associated with the follow-up procedure (e.g., colposcopy). Pointer to the WV Procedure (#790.1) file.

T-Zone Seen Entirely:
This field documents (set of codes: 1 = Yes, 0 = No) that the T-Zone in the colposcopy/biopsy procedure was adequately visualized.

Multifocal:
This field documents (set of codes: 1 = Yes, 0 = No) that the lesion seen during the procedure was multifocal (as opposed to unifocal).

Lesion Outside Canal:
This field documents (set of codes: 1 = Yes, 0 = No) that the lesion seen during the procedure was outside the canal.

Number of Quadrants:
This field contains a number (0-4) that identifies the number of quadrants occupied by the lesion.

Satisfactory Exam:
This field documents that the procedure or gynecologic exam was satisfactorily performed without any impediments. Set of codes (1 = Yes, 0 = No).

Quadrant Locations:
The location of the affected quadrants. Any of the following abbreviations may be selected: UL,LL,UR,LR. If more than one quadrant is included, separate them with a comma.

Impression:
This field contains the impression of the clinician performing the exam. Pointer to the WV Results/Diagnosis (#790.31) file.

Page 3 (for colposcopy only):

ECC Dysplasia:
This field indicates if ectocervical dysplasia was present, if an insufficient tissue sample was provided, or the sample was not examined for dysplasia.

Margins Clear:
This field indicates tissue sample showed no pathology at the margins of the tissue sample.

Ectocervical Biopsy:
This field contains the diagnosis or impression resulting from the cytology examination. Pointer to the WV Results/Diagnosis (#790.31) file.

Stage:
This field documents the clinical stage for invasive carcinoma of the cervix. If clinical stage is unknown, enter the summary ('S-') stage.

STD Evaluation:
This field documents the findings after testing for sexually transmitted diseases. Pointer to the WV Results/Diagnosis (#790.31) file.

Page 4:

Notes:
This is text describing the results/diagnosis of the procedure.

WV ADD AN HISTORICAL PROCEDURE

Add an HISTORICAL Procedure

This option allows you to add procedures for a patient done in years past, in order to make her Patient Profile more complete. Only a minimum of data is required: date of procedure, procedure, results, HPV status and an optional health care facility.

If you wish to enter more of the data on a procedure from years past, you may of course add the procedure through the standard Add a NEW Procedure option. There is no requirement to add an old procedure under the Historical option. It is important, however, that current procedures be added under the Add a NEW Procedure option, where many more of the important and relevant fields are available for entering data. Procedure data is stored in the WV Procedure (#790.1) file.

Field Descriptions:

Patient Name:
This field contains the name of the patient associated with the procedure. Pointer to the WV Patient (#790) file.

Procedure:
This field stores the name of the procedure performed on the patient. Pointer to the WV Procedure (#790.1) file.

Date:
This field contains the date that the procedure was performed.

Results/Diagnosis:
This field stores the main result or diagnosis of the patient's procedure. Pointer to the WV Results/Diagnosis (#790.31) file. The diagnosis or results for PAP smears are based on the Bethesda Classification system; those for mammograms use the American College of Radiology classification. Entries should not be locally edited. A list of the possible results/diagnosis for each procedure type is found in Appendix A.

HPV:
This field is used to document the presence or absence of the Human Papilloma Virus (HPV) in the cytology reports.

Health Care Facility:
This field identifies the name of the health care facility where this procedure was performed.

WV REFUSED PROC-ADD

Add a Refusal of Treatment

This option allows you to document a refusal of treatment if the patient declines to be treated at this treatment site for any reason. Refusal of treatment data is stored in the WV Refusals (#790.3) file.

Field Descriptions:

These fields appear above the dashed line on every screen. These fields are not editable through this option. They may be edited through Edit/Print Patient Case Data option (except patient name and SSN).

Patient Name:
This field contains the name of the patient associated with the procedure. Pointer to the WV Patient (#790) file.

SSN:
This field contains the social security number of the patient.

Case Manager:
This field contains the name of a WH case manager assigned to manage this women's health needs.

PAP Regimen:
This field contains the PAP regimen that was given to this patient at the date and time of this entry.

Cervical Treatment Need:
This field contains the name of the current or next gynecologic procedure or treatment need scheduled for this patient.

Cervical Treatment Facility:
This field contains the name of the facility responsible for providing the gynecological tests/exams for this patient. Facility choices are limited to entries in the Institution (#4) file.

Breast Treatment Need:
This field contains the name of the current or next breast study procedure needed for this patient.

Breast Treatment Facility:
This field contains the name of the facility responsible for providing the breast study tests/exams for this patient. Facility choices are limited to entries in the Institution (#4) file.

Sexual Trauma:
This field indicates if the patient has experienced any sexual trauma (rape, sexual assault, etc.) either in the military and/or as a civilian. Set of codes: (M = Military, C = Civilian, B = Both).

Veteran:
This field contains a 'Yes' if the patient is a veteran, 'No' if the patient is not a veteran, or is blank if the veteran status of this patient is not known.

These fields appear below the dashed line:

Date Refused:
This field contains the date the patient refused the procedure, test or examination.

Procedure:
This field stores the name of the procedure performed on the patient. Pointer to the WV Procedure (#790.1) file.

Reason:
This field indicates a general reason for why the patient refused treatment, i.e., (1) treatment was provided elsewhere, (2) no reason was given by the patient, or (3) another reason was provided by the patient.

Comments:
This field contains comments related to this refusal (limited to 3-75 characters).

WV REFUSED PROC-EDIT

Edit a Refusal of Treatment

This option allows editing of an existing patient's refusal for treatment. The user must identify the record to be edited by entering a date that the treatment was refused or by selecting from a list of records in the WV Refusals (#790.3) file. Refusal of treatment data is stored in the WV Refusals (#790.3) file.

Field Descriptions:

These fields appear above the dashed line on every screen. These fields are not editable through this option. They may be edited through Edit/Print Patient Case Data option (except patient name and SSN).

Patient Name:
This field contains the name of the patient associated with the procedure. Pointer to the WV Patient (#790) file.

SSN:
This field contains the social security number of the patient.

Case Manager:
This field contains the name of a WH case manager assigned to manage this women's health needs.

PAP Regimen:
This field contains the PAP regimen that was given to this patient at the date and time of this entry.

Cervical Treatment Need:
This field contains the name of the current or next gynecologic procedure or treatment need scheduled for this patient.

Cervical Treatment Facility:
This field contains the name of the facility responsible for providing the gynecological tests/exams for this patient. Facility choices are limited to entries in the Institution (#4) file.

Breast Treatment Need:
This field contains the name of the current or next breast study procedure needed for this patient.

Breast Treatment Facility:
This field contains the name of the facility responsible for providing the breast study tests/exams for this patient. Facility choices are limited to entries in the Institution (#4) file.

Sexual Trauma:
This field indicates if the patient has experienced any sexual trauma (rape, sexual assault, etc.) either in the military and/or as a civilian. Set of codes: (M = Military, C = Civilian, B = Both).

Veteran:
This field contains a 'Yes' if the patient is a veteran, 'No' if the patient is not a veteran, or is blank if the veteran status of this patient is not known.

These fields appear below the dashed line:

Date Refused:
This field contains the date the patient refused the procedure, test or examination.

Procedure:
This field stores the name of the procedure performed on the patient. Pointer to the WV Procedure (#790.1) file.

Reason:
This field indicates a general reason for why the patient refused treatment, i.e., (1) treatment was provided elsewhere, (2) no reason was given by the patient, or (3) another reason was provided by the patient.

Comments:
This field contains comments related to this refusal (limited to 3-75 characters).

WV ADD A NEW NOTIFICATION

Add a New Notification

This option allows you to add notifications for patients. A notification is a communication between the clinic staff and the patient.

When you add a notification, it must be given a type of notification. Most notifications are letters, however, they may also be phone calls, conversations, etc. The table below lists all of the types of notifications that are available in Women's Health:

CONTACT CHA	MESSAGE VIA PERSON
CONTACT PHN	MESSAGE VIA PHONE MACHINE
CONVERSATION WITH PATIENT	PHONE CALL, 1ST
LETTER, FIRST	PHONE CALL, 2ND
LETTER, SECOND	PHONE CALL, 3RD
LETTER, SECOND (CERTIFIED)	PROVIDER CONSULT
LETTER, THIRD (CERTIFIED)	

When you add a notification, it must also be given a purpose of notification. The purpose of notification is the reason the patient is being contacted. The table below lists the purposes of notification that come pre-loaded in Women's Health. It is possible to add other purposes of notification customized to your particular site, and to edit the ones listed below as well. (See Add/Edit a Notification Purpose & Letter option.)

COLP Abnormal, need further Tx
COLP follow up, PAP next month.
COLP follow up, next PAP 6 months.
DNKA Colposcopy (Did Not Keep Appt)
DNKA Colposcopy Follow Up
DNKA PAP routine
DNKA PAP asap
DNKA PAP urgent
MAM result normal, next MAM 1 year.
PAP abnormal, need colp 8-12 weeks PP.
PAP result abnl, rep PAP 3-6 mos.
PAP result abnormal, PAP 6 weeks P.P.
PAP result abnormal, next PAP 3 months and colp.
PAP result abnormal, schedule colposcopy.
PAP result normal, next PAP 1 year.
PAP result normal, next PAP 4 months.
PAP result normal, next PAP 6 months.

PAP, annual due.
PAP, follow-up due.
PREGNANCY Test NEGATIVE
PREGNANCY Test POSITIVE

Eventually, each notification should be given an outcome. The outcome of a notification describes the final result of the contact with the patient. The table below lists the outcomes that come pre-loaded in Women's Health. It is possible to add other outcomes customized to your particular site, and to edit the ones listed below as well. (See Add/Edit Notification Outcomes option.)

Chart Flagged
Declined Tx
MAM Normal letter sent
No known address
No response
PAP Normal letter sent
PHN referral
Patient Deceased
Patient left Service Area
Provider consult
Response not tracked
Scheduled appt for Colposcopy
Scheduled appt for PAP
Scheduled appt for Repeat PAP
Tx elsewhere
Unable to contact Patient

As stated above, this option allows you to add notifications for patients. The first prompt asks you to select a patient (either by name, or SSN). After you have selected a patient, the 'Edit a Notification' screen appears. Notification data is stored in the WV Notification (#790.4) file.

Field Descriptions:

These fields appear above the dashed line on every screen. These fields are not editable through this option. They may be edited through Edit/Print Patient Case Data option (except patient name and SSN).

Patient Name:
This field contains the name of the patient associated with the procedure. Pointer to the WV Patient (#790) file.

SSN:
This field contains the social security number of the patient.

Case Manager:
This field contains the name of a WH case manager assigned to manage this women's health needs.

PAP Regimen:
This field contains the PAP regimen that was given to this patient at the date and time of this entry.

Cervical Treatment Need:
This field contains the name of the current or next gynecologic procedure or treatment need scheduled for this patient.

Cervical Treatment Facility:
This field contains the name of the facility responsible for providing the gynecological tests/exams for this patient. Facility choices are limited to entries in the Institution (#4) file.

Breast Treatment Need:
This field contains the name of the current or next breast study procedure needed for this patient.

Breast Treatment Facility:
This field contains the name of the facility responsible for providing the breast study tests/exams for this patient. Facility choices are limited to entries in the Institution (#4) file.

Sexual Trauma:
This field indicates if the patient has experienced any sexual trauma (rape, sexual assault, etc.) either in the military and/or as a civilian. Set of codes: (M = Military, C = Civilian, B = Both).

Veteran:
This field contains a 'Yes' if the patient is a veteran, 'No' if the patient is not a veteran, or is blank if the veteran status of this patient is not known.

These fields appear below the dashed line:

Accession#:
This is the record number assigned by the Women's Health package. It is composed of the procedure's abbreviated code, a four digit year and a sequential number.

Procedure:
This field stores the name of the procedure performed on the patient. Pointer to the WV Procedure (#790.1) file.

Date Notification Opened (Required):
This field contains the date the notification was first created.

Facility (Required):
Select the health care facility with which this letter is associated. Each letter to be printed is associated with a specific facility. When a user runs the Print Queued Letters option, only letters associated with the user's facility will be printed. (The user's facility is the facility (also called 'Site' or 'Division') that the user selects at sign on. If a user has only one facility, that facility is assigned automatically. For more information about selecting facilities at sign on, contact your site manager or ADPAC.) This feature allows multiple clinics to manage patients and print letters on the same computer, using the same patient database, without printing another clinic's letters.

Purpose of Notification (Required):
This field contains the reason for the notification (e.g., the results of a test, reminder to schedule a procedure). This should be brief but descriptive enough to identify it uniquely. NOTE: This field cannot be changed because previous notifications from this purpose would become inaccurate. If the Purpose field is incorrect, make this purpose 'Inactive' (see next field), and then create a new purpose of notification with the correct purpose name.

Priority:
Filled in automatically, based on the purpose of notification.

Type of Notification:
This field stores the method used to notify the patient from the choices available in the WV Notification Type (#790.403) file (e.g., letter, phone call, message, etc.).

Print Date:
Date letter is to be printed. Once the letter has a 'Print Date', it will print out on that date (or on any later date) when the option Print Queued Letters is run. For example, if the letter is queued to print on Friday but Print Queued Letters is not run until the following Monday, then the letter will print out with the Monday batch.

The default date that appears is based on whether the letter is a results letter or a reminder letter. If it is a results letter, the default date is 'Today'. If it is a reminder letter, the default date is based on the due date of the treatment need (breast or gynecologic) to which this purpose of notification relates. (See the Add/Edit a Notification Purpose & Letter option.)

Complete by (Date):
This field contains the date used to determine that this procedure record is delinquent when a close status has not been entered in the record.

Printed:
Filled in automatically when the letter (if the notification is a letter) is printed.

Outcome:
This field stores the results or outcome, which may be a goal or an event, associated with this patient's notification.

Status:
Select either 'Open' or 'Closed'. A notification is usually left 'Open' until an outcome has been entered. If the notification is a results letter, it is usually closed when the letter is printed (no further outcome is expected). If the notification is a reminder letter (reminding the patient to call for a next appointment), it is usually closed either when the patient calls to schedule an appointment, or following the edit of her next procedure. (See 'The Basic Patient Management Loop'). A notification that is left 'Open' past its 'Complete by (Date)' will be displayed as 'Delinquent' on notification reports.

Patient Education:
Enter 'Yes' or 'No', depending on whether patient education occurred during the notification (for phone calls, conversations, etc.).

NOTE: If the notification is a letter and the letter has already been printed, most of the fields for that notification will be blocked from editing. This is to keep the data on the computer in sync with the letter that was sent to the patient. Only the bottom four fields (Complete by Date, Outcome, Status, and Patient Ed) will be editable.

After you leave the 'Edit a Notification' screen, if you did not save before exiting you will be asked 'Save changes before leaving form (Y/N)?', and if the notification was a letter, the program will ask, 'Do you wish to preview or print this letter now? Enter Yes or No: NO//'. 'Preview' allows you to look at the letter that has just been queued. To preview the letter, select 'Home' at the 'Device: ' prompt. 'Print' will print the letter immediately, regardless of its 'Print Date', and remove it from the queue of letters waiting to print. To print the letter immediately, select a printer at the 'Device: ' prompt.

If you answer 'No' to the 'Do you wish to preview or print this letter now?' prompt, the letter will remain in the queue, to be printed on its 'Print Date'. NOTE: These letters do not print automatically, the user should run the Print Queued Letters option to print the letters.

After the 'Edit a Notification' screen the program will ask, 'Do you wish to edit this patient's case data?'. Answer 'Yes' if you wish to update the patient's case data at this point. (See the Edit/Print Patient Case Data option in this chapter.)

WV EDIT NOTIFICATION

Edit a Notification

This option allows you to edit a notification that already exists. You are first asked to select a patient (by name or SSN), and then a notification (by date or accession#). Once you have selected a notification to edit, the 'Edit a Notification' screen will appear. Notification data is stored in the WV Notification (#790.4) file.

Field Descriptions:

These fields appear above the dashed line on every screen. These fields are not editable through this option. They may be edited through Edit/Print Patient Case Data option (except patient name and SSN).

Patient Name:
This field contains the name of the patient associated with the procedure. Pointer to the WV Patient (#790) file.

SSN:
This field contains the social security number of the patient.

Case Manager:
This field contains the name of a WH case manager assigned to manage this women's health needs.

PAP Regimen:
This field contains the PAP regimen that was given to this patient at the date and time of this entry.

Cervical Treatment Need:
This field contains the name of the current or next gynecologic procedure or treatment need scheduled for this patient.

Cervical Treatment Facility:
This field contains the name of the facility responsible for providing the gynecological tests/exams for this patient. Facility choices are limited to entries in the Institution (#4) file.

Breast Treatment Need:
This field contains the name of the current or next breast study procedure needed for this patient.

Breast Treatment Facility:
This field contains the name of the facility responsible for providing the breast study tests/exams for this patient. Facility choices are limited to entries in the Institution (#4) file.

Sexual Trauma:
This field indicates if the patient has experienced any sexual trauma (rape, sexual assault, etc.) either in the military and/or as a civilian. Set of codes: (M = Military, C = Civilian, B = Both).

Veteran:
This field contains a 'Yes' if the patient is a veteran, 'No' if the patient is not a veteran, or is blank if the veteran status of this patient is not known.

These fields appear below the dashed line:

Accession#:
This is the record number assigned by the Women's Health package. It is composed of the procedure's abbreviated code, a four digit year and a sequential number.

Procedure:
This field stores the name of the procedure performed on the patient. Pointer to the WV Procedure (#790.1) file.

Date Notification Opened (Required):
The date the notification was first created.

Facility (Required):
Select the health care facility with which this letter is associated. Each letter to be printed is associated with a specific facility. When a user runs the Print Queued Letters option, only letters associated with the user's facility will be printed. (The user's facility is the facility (also called 'Site' or 'Division') that the user selects at sign on. If a user has only one facility, that facility is assigned automatically. For more information about selecting facilities at sign on, contact your site manager.) This feature allows multiple clinics to manage patients and print letters on the same computer, using the same patient database, without printing one another's letters.

Purpose of Notification (Required):
This field contains the reason for the notification (e.g., the results of a test, reminder to schedule a procedure). This should be brief but descriptive enough to identify it uniquely. NOTE: This field cannot be changed because previous notifications from this purpose would become inaccurate. If the Purpose field is incorrect, make this purpose 'Inactive' (see next field), and then create a new purpose of notification with the correct purpose name.

Priority:
Filled in automatically, based on the purpose of notification.

Type of Notification:
This field stores the method used to notify the patient from the choices available in the WV Notification Type (#790.403) file (e.g., letter, phone call, message, etc.).

Print Date:
Date letter is to be printed. Once the letter has a 'Print Date', it will print out on that date (or on any later date) when the option Print Queued Letters is run. For example, if the letter is queued to print on Friday but Print Queued Letters is not run until the following Monday, then the letter will print out with the Monday batch.

The default date that appears is based on whether the letter is a results letter or a reminder letter. If it is a results letter, the default date is 'Today'. If it is a reminder letter, the default date is based on the due date of the treatment need (breast or gynecologic) to which this purpose of notification relates. (See the Add/Edit a Notification Purpose & Letter option.)

Complete by (Date):
This field contains the date used to determine that this procedure record is delinquent when a close status has not been entered in the record.

Printed:
Filled in automatically when the letter (if the notification is a letter) is printed.

Outcome:
This field stores the results or outcome, which may be a goal or an event, associated with this patient's notification.

Status:
Select either 'Open' or 'Closed'. A notification is usually left 'Open' until an outcome has been entered. If the notification is a results letter, it is usually closed when the letter is printed (no further outcome is expected). If the notification is a reminder letter (reminding the patient to call for a next appointment), it is usually closed either when the patient calls to schedule an appointment, or following the edit of her next procedure. (See 'The Basic Patient Management Loop'). A notification that is left 'Open' past its 'Complete by (Date)' will be displayed as 'Delinquent' on notification reports.

Patient Education:
Enter 'Yes' or 'No', depending on whether patient education occurred during the notification (for phone calls, conversations, etc.).

NOTE: If the notification is a letter and the letter has already been printed, most of the fields for that notification will be blocked from editing. This is to keep the data on the computer in sync with the letter that was sent to the patient. Only the bottom four fields (Complete by Date, Outcome, Status, and Patient Ed) will be editable.

After you leave the 'Edit a Notification' screen, if you did not save before exiting you will be asked 'Save changes before leaving form (Y/N)?', and if the notification was a letter, the program will ask, 'Do you wish to preview or print this letter now? Enter Yes or No: NO//'. 'Preview' allows you to look at the letter that has just been queued. To preview the letter, select 'Home' at the 'Device: ' prompt. 'Print' will print the letter immediately, regardless of its 'Print Date', and remove it from the queue of letters waiting to print. To print the letter immediately, select a printer at the 'Device: ' prompt.

If you answer 'No' to the 'Do you wish to preview or print this letter now?' prompt, the letter will remain in the queue, to be printed on its 'Print Date'. NOTE: These letters do not print automatically, the user should run the Print Queued Letters option to print the letters.

After the 'Edit a Notification' screen the program will ask, 'Do you wish to edit this patient's case data?'. Answer 'Yes' if you wish to update the patient's case data at this point. (See the Edit/Print Patient Case Data option in this chapter.)

WV BROWSE NOTIFICATIONS

Browse Notifications

This option allows you to search for and browse through notifications. The six questions that are asked prior to the display allow you to specify patients, date range, status, case manager (site parameter), order of display, and device for the printout.

If the device selected for the 'Browse Notifications' display is 'Home' (to the screen), a column of numbers will appear to the left of the notifications. Notification data is stored in the WV Notification (#790.4) file.

Report Description:

SSN:
This field contains the social security number of the patient.

Patient:
This field contains the name of the patient associated with the procedure. Pointer to the WV Patient (#790) file.

Date:
This field contains the date the procedure was performed.

Accession#:
This is the record number assigned by the Women's Health package. It is composed of the procedure's abbreviated code, a four digit year and a sequential number.

Status:
This field contains the record's status (set of codes: O = Open, C = Closed, D = Delinquent) for the procedure. The value of this field is used in the Program Snapshot reports and the Browse Patients with Needs Past Due report.

Priority:
This field associates a priority with the notification. The priority choices are: urgent, ASAP, and routine.

WV PRINT INDIVIDUAL LETTERS

Print Individual Letters

This option allows you to print individual letters. You are first asked to select a patient (by name or SSN), then a notification (by date or accession#), and then a printer device. The letter will print immediately (unless you queue it again), regardless of its 'Print Date', and then it will be removed from the queue of letters waiting to print. Letters are printed as needed by merging notification data (File #790.4) with a notification form letter (File #790.404).

WV PRINT QUEUED LETTERS

Print Queued Letters

This option allows you to print all letters that have been queued to print on the current date or on any date prior to the current date. Some of these letters may be reminder letters, put in the queue weeks or months earlier to print on this date, alerting the patient to call and schedule her next procedure (for example, an annual PAP). Others of these letters may be results letters queued earlier in the day to print today, informing the patient of results of a recent procedure. Only letters associated with your facility will be printed (see 'Facility'). Letters are printed as needed by merging notification data (File #790.4) with a notification form letter (File #790.404).

NOTE: The option to Print Queued Letters checks to see that the patient is not deceased. For a deceased patient, instead of the queued letter printing, an explanation is printed stating that the patient is deceased, that letter will not be printed, and that the notification has been closed and given an outcome of 'Patient Deceased'. At this time, the user should edit the deceased patient's case data and enter a date into the Inactive Date field. Refer to the Edit Patient Case Data explanation for additional information.

Appendix B - Examples of Major Screen Edits

WV EDIT PATIENT CASE DATA

Edit/Print Patient Case Data

```
                    * * *  EDIT PATIENT CASE DATA  * * *

Patient Name: TEST,NANCY (49y/o)                    SSN: 088-88-8888
      Street: 1722 E 71ST PL                Patient Phone: 312-375-3743
  Cty/St/Zip: CHICAGO, IL  60649              Pr Provider: TEST,KEITH
     Veteran: YES
_____________________________________________________________________________

      Case Manager: TEST,FRANK                  Inactive Date:
    Breast Tx Need: Mammogram, Screening      Cervical Tx Need: Routine PAP
Breast Tx Due Date: JUN 1,1998            Cervical Tx Due Date: JUN 1,1998
Breast Tx Facility: Hines                 Cervical Tx Facility: Hines
           PAP Regimen: Pq6mx2, Pqy
PAP Regimen Start Date: JUN 1,1998                  Sexual Trauma: Civilian
Family Hx of Breast CA: no family history              Notes (WP):
    Currently Pregnant: NO     EDC:                 DES Daughter: NO
 Date of 1st Encounter: MAY 18,1998               Refe rral Source: Provider
_____________________________________________________________________________
Exit     Save     Refresh

Enter a command or '^' followed by a caption to jump to a specific field.


Do you wish to PRINT this patient's Case Data?
Enter Yes or No: NO// <RET>
```

WV ADD A NEW PROCEDURE

Add a NEW Procedure

```
              * * *  WOMEN'S HEALTH: ADD A NEW PROCEDURE  * * *


Select PATIENT NAME: TEST,NANCY           02-28-49     088888888     YES
SC VETERAN
   Select PROCEDURE: PAP SMEAR// COLPOSCOPY W/BIOPSY       CO
   Select DATE:      TODAY// <RET>  (JUL 8, 1998)  JUL 8, 1998


 * Move to PAGE 2 to edit clinical and pathology findings.


                 * * *  EDIT A PROCEDURE  * * *
Patient Name: TEST,NANCY(49y/o)                          SSN: 088-88-8888
Case Manager: TRAXLER,FRANK                  Procedure: COLPOSCOPY W/BIOPS
PAP Regimen : Pq6mx2, Pqy (began JUN 01,1998)        Acc#: CO1998 -9
Cx Tx Need  : Routine PAP (by JUN 01,1998)     Cx Facility: Hines
Br Tx Need  : Mammogram, Scrn (by JUN 01,1998) Br Facility: Hines
Sexual Trauma: Civilian                          Veteran: Yes
-------------------------------------------------------------------------------
     Date of Procedure: JUL 8,1998
    Clinician/Provider: TEST,KEITH
  Ward/Clinic/Location: EMPLOYEE HEALTH                    Reports (WP):
  Health Care Facility: HINES                                Notes (WP):
              Comments:
    Complete by (Date): AUG 7,1998
     Results/Diagnosis: WNL/Normal                          HPV: YES
 Sec Results/Diagnosis:                                  Status: OPEN
                                                            (PAGE 1  OF 2)
_______________________________________________________________________________
Exit     Save     Next Page     Refresh

Enter a command or '^' followed by a caption to jump to a specific field.


COMMAND: N                                  Press <PF1>H for help    Insert
```

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